No. 15-7

IN THE

Supreme Court of the United States

UNIVERSAL HEALTH SERVICES, INC.,

Petitioner,

v.

UNITED STATES AND COMMONWEALTH OF MASSACHUSETTS EX REL. JULIO ESCOBAR AND CARMEN CORREA,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the First Circuit

BRIEF *AMICI CURIAE* OF THE JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW, MENTAL HEALTH AMERICA, AND THE SERVICE EMPLOYEES INTERNATIONAL UNION SUPPORTING RESPONDENTS

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INTERESTS OF *AMICI CURIAE*

Founded in 1972 as the Mental Health Law Project, the Judge David L. Bazelon Center for Mental Health Law is a national nonprofit legal advocacy organization that works to advance the rights and dignity of adults and children with mental disabilities.[1] Through litigation, public policy advocacy, education, and training, the Center has advocated for equal opportunities for individuals with mental disabilities in all aspects of life, including health care, and access to the services they need to live independent lives and participate fully in their communities. The Center has participated as *amicus* in numerous cases involving the rights of individuals with mental disabilities heard by the U.S. Supreme Court.

Amicus curiae Mental Health America ("MHA"), formerly the National Mental Health Association, is a national membership organization composed of individuals with lived experience of mental illnesses and their family members and advocates. The nation's oldest and leading community-based nonprofit mental health organization, MHA has more than 200 affiliates dedicated to improving the mental health of all Americans, especially the 54 million people who have severe mental disorders. Through advocacy, education, research, and service, MHA helps to ensure that people with mental illnesses are accorded respect, dignity, and the opportunity to achieve their full potential. MHA is

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[1] No counsel for a party authored this brief in whole or in part, and no person or entity other than *amici curiae* made a monetary contribution to the preparation or submission of this brief. All parties consented to the filing of this brief.

concerned that a lack of oversight and resources for enforcing basic quality standards in treatment settings results in serious safety concerns and creates significant barriers to recovery.

Amicus curiae Service Employees International Union ("SEIU") is the largest healthcare union in the United States. More than half of SEIU's two million members work in healthcare, including 85,000 registered nurses in twenty-one states who are united in SEIU's Nurse Alliance; doctors in a wide range of specialties who have joined together in SEIU's Doctors Council, which is currently led by a psychiatrist; and 52,000 members of 1199SEIU United Healthcare Workers East who work in healthcare in Massachusetts, where Yarushka Rivera received treatment.

SEIU members who have dedicated their lives to providing high-quality, cost-effective healthcare have a strong interest in eliminating fraud that undermines their work. SEIU members also have an interest in preserving a vibrant False Claims Act ("FCA") because, as healthcare employees, they are whistleblowers and potential whistleblowers regarding fraud they witness. Finally, SEIU members in healthcare and other fields have an interest as Medicare and Medicaid participants in ensuring that the FCA reaches all knowing and material fraud against the government.

INTRODUCTION AND SUMMARY OF ARGUMENT

Petitioner Universal Health Services ("UHS") paints this case as involving a one-off violation of "technical" requirements by an innocent provider attempting in good faith to comply with arcane regulations. Pet'r's Br. 50. But the reality is far different.

UHS has a long history of repeated and serious violations of regulatory requirements regarding staffing, licensure, and supervision, and those violations have had devastating consequences for the patients in UHS's care. The company's poor record highlights (1) the importance of proper staffing and supervision to patient health and the government's reimbursement decisions, and (2) the importance of the FCA's implied-certification liability and whistleblower provisions in assisting the government's efforts to root out fraud.

As discussed *infra* Part I, UHS's "history of staffing problems ... around the country" includes numerous examples of "incompetent clinical staff," Chelsea Conaboy, *National Reviews of Centers Rare in Mental Health*, Boston Globe, Nov. 11, 2013, inadequate staffing ratios, *see id.*, and untrained and unsupervised therapists, *see* Conaboy, *Mental Health Clinics Cited*, Boston Globe, June 20, 2013. The company's staffing problems have been linked to patient injuries and death, *see, e.g.*, Conaboy, *Staff Failures Cited in Deaths at Arbour Psychiatric Ctrs.*, Boston Globe, Sept. 1, 2013, yet UHS continues its unlawful practices year after year and in facility after facility.

UHS is able to continue in this way at least in part because regulators lack the resources and authority to deter systemic misconduct. The administrative agencies charged with overseeing Medicare and Medicaid providers are often under-funded, *see, e.g.*, Megan Twohey, *State Declines to Investigate Vast Majority of Hospital Complaints*, Chi. Trib., Nov. 6, 2011; incapable of spotting "patterns, particularly across state lines," Conaboy, *National Reviews*, *supra*; and without authority "to levy fines" or impose other "meaningful sanctions" short of termination from the relevant program, which is a drastic, rarely taken step, Joe Carlson, *Cleveland Clinic Cases Highlight Flaw in Safety Oversight*, Modern Healthcare, June 7, 2014, *available at* http://www.modernhealthcare.com/article/20140607/MAGAZINE/306079939. Oversight agencies are thus left in many cases with meaningless "plans of correction," which companies like UHS violate soon after their submission.

UHS's record of repeat violations seems even more alarming when considered in light of some of the company's statements and its increasing role in our mental healthcare system. Speaking at a 2013 conference, UHS's CFO emphasized that the company's behavioral health business receives "fairly minimal" scrutiny from payers, allowing that business to "operate, I don't want to say sort of invisibly, but certainly under [Medicare's] radar." Steve Filton, *Presentation at Cowen Health Care Conference* 5 (Mar. 4, 2013), http://researchdocuments.org/Docs/Universal_Health_Services_at_Cowen_FD_Fair_Disclosure_Wire_March_4_2013.pdf [hereinafter Filton, *2013 Presentation*]. Mr. Filton also said UHS "benefit[s]" from treating patients who are "not in a position to" make decisions about

their own care, *e.g.*, because they are "suicidal" or have "overdosed on drugs or alcohol." *Id.* at 3.

Meanwhile, UHS continues to grow its mental and behavioral health capacity, subjecting more and more patients to its minimally scrutinized, under-the-radar care. UHS now captures 15-20% of all mental healthcare revenue nationwide. *See* Steve Filton, *Presentation at Bank of Am. Merrill Lynch 2015 Leverage Fin. Brokers Conference* (Dec. 3, 2015), http://seekingalpha.com/article/3732436-universal-health-services-uhs-presents-at-bank-of-america-merrill-lynch-2015-leveraged-finance-brokers-conference-transcript [hereinafter Filton, *2015 Presentation*]. UHS's mental health facilities have 21,000 beds, UHS, *2014 Annual Report* 17, http://www.uhsinc.com/media/288196/2014-annual-report.pdf, and UHS earns five times more revenue from freestanding mental health facilities than its closest competitor. *See* Filton, *2015 Presentation*, *supra*.

UHS's poor record and oversight agencies' limitations highlight the importance of the FCA's implied-certification liability and whistleblower provisions, which help combat fraud without imposing anything approaching "catastrophic" liability. *Contra* Pet'r's Br. 55. Implied-certification claims add much-needed deterrence value with respect to knowing and material rule violations, and the prospect of a financial reward for reporting such misconduct encourages whistleblowers to come forward. *See infra* Part II.A. Implied-certification liability is reasonably and appropriately limited, however, so it does not interfere with providers' ability to succeed, as data and UHS's own experience demonstrate. *See infra* Part II.B.

For these and other reasons, *amici* urge this Court to affirm the First Circuit's decision so that relators' case may proceed.

ARGUMENT

I. MORE THAN "TECHNICAL" VIOLATIONS ARE AT STAKE IN THIS CASE.

UHS's brief may describe this case in terms of "technical" rule violations, Pet'r's Br. 50, and teen summer jobs, *see id.* at 3, but UHS's record tells a very different story about what is at stake for the patients in its care. Publicly available data show the "history of staffing problems" that the Boston Globe described: Again and again UHS has employed unqualified, untrained, and inadequately supervised staff at its facilities nationwide—and again and again patients have suffered as a result. Federal and state regulators, hamstrung by their limited resources and inadequate remedial arsenal, have so far been unable to provide lasting, systemic relief for the patients in UHS's care.

A. The Example of UHS's National Deaf Academy

UHS's National Deaf Academy ("NDA") provides a telling example of the company's personnel practices and of the harm suffered by patients as a result.

NDA, a residential treatment facility in Mt. Dora, Florida, has been cited repeatedly for staffing violations. A 2013 inspection found several staff members who said they had not been given the training they needed to care for their patient, a non-verbal child with bipolar disorder. *See* Fla. Agency for Health Care Admin. ("AHCA"), *Statement of Deficiencies & Plan of Correction* ("*SDPC*") 1, 3–4

(inspection Apr. 11, 2013), http://researchdocuments.org/Docs/FL-National-Deaf-Academy-2013.4.11.pdf. NDA submitted a plan of correction, *id.*, but when inspectors returned in 2014, they again found staff members who had not been given needed training, including with respect to abuse-incident reporting. *See* AHCA, *SDPC* 6–7 (inspection Dec. 24, 2014), http://researchdocuments.org/Docs/FL-SOD-National-Deaf-Academy-2014.12.24-5848489.pdf [hereinafter *Dec. 24, 2014 SDPC*].

While UHS might try to dismiss violations like these as "technical" or "obscure," Pet'r's Br. 50, the children at NDA experienced much more than technical harm. Between 2004 and 2014, Florida's Department of Children and Families found evidence of physical abuse, sexual abuse, and inadequate supervision at NDA. *See* Aliza Nadi, *'Mom Please Help': FBI Probing Alleged Abuse of Deaf, Autistic Kids*, NBC News (Sept. 14, 2014), http://www.nbcnews.com/news/investigations/mom-please-help-fbi-probing-alleged-abuse-deaf-autistic-kids-n193846. Three NDA patients died between 2009 and 2014 in allegedly negligent circumstances, and one former NDA employee told reporters she called an abuse hotline a dozen times in just one six-week period. *See id.*; *cf.* Conaboy, *Staff Failures*, *supra* (discussing "three questionable deaths within 18 months in the [UHS] Arbour Health System that involved staff failures identified by state or federal health regulators").

Parents and former NDA employees tell of horrible abuse involving the facility's very young patients. The parents of one former NDA patient told NBC News that they were initially excited to find a facility that might help their autistic and

bipolar son, but, after hearing from their insurance company about alleged abuse at NDA, returned to the facility to find that their 10-year-old boy had lost 22 pounds, had scabies, and reported being punched in the face and providing "massages" to a staff member. *See* Nadi, *FBI Probing*, *supra*. The boy reported pain in his penis when taken to the hospital, and a medical examination also found rectal bleeding. *See id.*

Another family told NBC that their adopted son used sign language to describe abuse he had suffered at NDA. *See id.* Another pulled their deaf child from the facility after the child's grandmother saw abrasions and a bruise. *See id*; *see also* Aliza Nadi, *Deaf Girl Says Staffer Broke Her Arm at Facility Being Probed by FBI*, NBC News (Sept. 18, 2014), http://www.nbcnews.com/news/investigations/deaf-girl-says-staffer-broke-her-arm-facility-being-probed-n193856.

Not surprisingly given NDA's training failures with respect to abuse-incident reporting, the facility did not investigate and report all allegations of abuse. *See, e.g.*, *Dec. 24, 2014 SDPC*, *supra*, at 8–9, 13–14; *see also* Nadi, *FBI Probing*, *supra*. One former employee told reporters about a severely disabled boy so desperate to communicate what was happening at the facility that he wrote "Mom, please help" in a card he sent home for Mother's Day. Nadi, *FBI Probing*, *supra*.

Patients and former employees also say they were silenced when they tried to blow the whistle. In an interview with state investigators, one patient reported seeing staff drag another patient so that her face hit a door, after which several staff members agreed not to report the incident because

the patient "always hits herself anyway." *Dec. 24, 2014 SDPC*, *supra*, at 10–11. The witnessing patient said that staff tried to intimidate her after she reported the incident, and state officials found no indication that NDA investigated either the alleged abuse or the alleged retaliation. *Id.* at 8, 12–14.

In addition, two former NDA employees told reporters that they were instructed not to call an abuse hotline and to document abuse incidents on company forms rather than in patient records. *See* Nadi, *FBI Probing*, *supra*. Both employees alleged they were fired after sending letters to UHS officials about the abuse they had seen. *Id.*

Fortunately, litigation seems to have led the way to relief for NDA patients in a way that infrequent inspections and repeat plans of correction could not. After years of lawsuits filed against the facility, NDA announced in January 2016 that it would finally shut its doors. *See, e.g.*, Livi Stanford, *Troubled National Deaf Academy Closes*, The Daily Commercial, Jan. 15, 2016, http://www.dailycommercial.com/news/article_099e6596-f013-597b-9ef2-71a1b2925833.html. The U.S. Department of Justice ("DOJ") has also notified UHS of an (apparently still-ongoing) criminal investigation encompassing NDA. *See* UHS, *Form 8-K* 3 (March 31, 2015), http://www.sec.gov/Archives/edgar/data/352915/000119312515113094/d898400d8k.htm; *see also, e.g.*, Harold Brubaker, *Firm under Federal Probe Owns 4 of 5 Most Profitable Pa. Mental Hospitals*, Phila. Inquirer, Nov. 18, 2015.

B. UHS's Nationwide Record of Violations and the Company's and Regulators' Inadequate Responses

National Deaf Academy is just one of UHS's many facilities nationwide. The company's mental health division has 217 facilities in thirty-seven states with more than 21,000 beds. *See* UHS, *2014 Annual Rep.*, *supra*, at 14, 17. Many of UHS's beds are filled by the "most vulnerable" patients: children as young as four years old. *Acute Inpatient Hospitalization*, Kempsville Ctr. for Behavioral Health, http://kempsvillecbh.com/acute-inpatient-stabilization/ (last visited Feb. 26, 2016).

Public records show serious and repeated staffing violations at UHS facilities across the country, including violations the company might dismiss as "technical" but that cause real harm.

1. UHS's Nationwide Record of Staffing Violations

Administrative agencies charged with overseeing UHS facilities have found many staffing violations in recent years, including in the areas of licensing and other job qualifications, training and supervision, and unsafe staffing levels. Inspectors have found such violations at UHS facilities in (at least) California, Connecticut, Florida, Georgia, Kentucky, Missouri, North Carolina, Ohio, Louisiana, Pennsylvania, Texas, Virginia, and Washington since 2009.

Unlicensed and unqualified staff. UHS facilities in North Carolina, Virginia, Pennsylvania, and California provide typical examples of the company's violations regarding licensing and other employee qualifications.

In North Carolina, a 2009 inspection of UHS's Old Vineyard Youth Services facility found that the facility knowingly promoted a former nurse whose license had been revoked "due to discipline"—and who failed to meet the facility's own requirements for the position—to be its Director of Acute Services, a role that involved working with mental health patients and supervising others doing the same. Ctrs. for Medicare & Medicaid Servs. ("CMS"), *SDPC* 1–2 (inspection Feb. 5, 2009), http://researchdocuments.org/Docs/NC-Old-Vineyard-2009.02.05-1.pdf.

In Virginia, a 2011 inspection of UHS's Kempsville Center, which treats children as young as four, found "systemic deficiencies" and a "major system failure" in the areas of "staff supervision," "[reference] verification," "training," and "unqualified mental health technician staff." Dep't of Behavioral Health & Developmental Servs. ["Va. DBHDS"], *Corrective Action Plan* 7 (inspection March 29, 2011), http://researchdocuments.org/Docs/VA-Kempsville-2011.03.29-CAP-87.pdf. Staff were working with expired certifications, inadequate education and experience, and, in the Acute Psychiatric Unit, lacked the minimum knowledge, skills and abilities to perform their duties. *Id.* at 1, 3–4.

In Pennsylvania, inspectors in 2012 reviewed twelve patient charts at UHS's Clarion Psychiatric Center and found that "[a]ll 12 charts included progress notes that reflected direct services being conducted by individuals whose qualifications did not support the nature of the work they were engaged in." Office of Mental Health & Substance Abuse Servs., Dep't of Public Welfare ["Pa. OMH"], *Licensing Inspection Summary* 1 (inspection Aug. 22, 2012), http://researchdocuments.org/Docs/PA-

Clarion-Psychiatric-Center-2012.08.22-Licensing-Summary.pdf.

And in California, UHS paid $4.25 million in 2012 to settle claims that employees at another of its facilities were either inappropriately credentialed or not credentialed at all and that the facility "warehouse[d]" children while fraudulently billing for the provision of meaningful services. Third Am. Compl., *Martin v. UHS of Del., Inc.*, No. 34-2009-044335-CU-FR-GDS (Sacramento Cnty., Cal., Super. Ct. Sep. 29. 2011); Stip. & Order Approving Settlement *etc.* (Aug. 9, 2012) (same case).

Other post-2009 examples of licensing and/or qualification violations at UHS facilities are cited in the margin.[2]

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[2] Va. DBHDS, *Investigation Findings Report* 1 (inspection Jan. 23, 2015), http://researchdocuments.org/Docs/VA-Hughes-Center-2015.01.23-Investigation-63.pdf (finding that mental health counselor did not meet qualifications for position at time of hire at UHS's Hughes Center); AHCA, *SDPC* 4–5 (inspection Jan. 7, 2015), http://researchdocuments.org/Docs/FL-SOD-Sandy-Pines-2015.01.07.pdf (in repeat violation, UHS's Sandy Pines Hospital failed to ensure that two of three employees demonstrated competency in restraint or seclusion semiannually as required; one of two employees nonetheless participated in restraint); AHCA, *SDPC* 4 (inspection Nov. 12, 2014), http://researchdocuments.org/Docs/FL-SOD-Palm-Shores-Behavioral-Health-Center-2014.11.12-5789445.pdf (similar violation at UHS's Palm Shores Behavioral Health Ctr.); Wa. State Dep't of Health, *SDPC* 9–10 (inspection Nov. 6, 2014), http://researchdocuments.org/Docs/WA-Schick-Shadel-SOD-2014.11.06-DOH.pdf (finding that infection control officer at UHS's Schick Shadel hospital had only received three credit hours of instruction related to infection control); CMS, *SDPC* 3–8 (inspection Sept. 10, 2014), http://researchdocuments.org/Docs/TX-SOD-Austin-Oaks-Hospital-2014.09.10.pdf (finding Director of Nursing at UHS's Austin Oaks Hospital in Texas

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Inadequate training and supervision. UHS's record is equally poor with respect to training and

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did not have required degree or qualifying education or experience); CMS, *SDPC* 2 (inspection Aug. 27, 2014), http://researchdocuments.org/Docs-WA-Fairfax-kirkland-SOD-2014.08.27.-DOH.pdf (finding that medical staff member's credentialing file showed only temporary privileges, valid for not more than 120 days, granted in 2012); AHCA, *SDPC* 6 (inspection May 22, 2014), http://researchdocuments.org/Docs/FL.Sandy-Pines-2014.05.22.pdf (Sandy Pines Hospital failed to ensure that employee demonstrated competency as required); Pa. OMH, *Licensing Inspection Summary* 2–3 (inspection Feb. 2014), http://researchdocuments.org/Docs/PA-Meadows-Inpatient-2014.02.10-DHS.pdf (UHS's Meadows Psychiatric Center failed adequately to verify credentials for two employees); CMS, *SDPC* 2, 7–9, 36 (inspection Aug. 15, 2013), http://researchdocuments.org/Docs/CT-SOD-Stonington-Institute-2013.08.15.pdf (finding that medical staff credentialing files at UHS's Stonington Institute in Connecticut were inadequate and that facility failed to have contract for qualified dietitian as required); Office of Licensing, Va. DBHDS, *Investigation Findings Rep.* 6 (inspection Jan. 23, 2013), http://researchdocuments.org/Docs/VA-Poplar-Springs-2013.01.23-Investigation-10.pdf (finding therapy was provided by employee not legally permitted to provide it at UHS's Poplar Springs facility); Tex. Dep't of State Health Servs., *SDPC* 24–25 (Nov. 29, 2012), http://researchdocuments.org/Docs/TX-UBH-of-El-Paso-2012.11.29-1.pdf (finding that UHS's University Behavioral Health of El Paso facility failed to verify licensure for five of five nurses whose records were reviewed and had no procedure in place to verify licensure); Office of Licensing, Va. DBHDS, *Corrective Action Plan* 2–3 (inspection Sept. 12, 2012), http://researchdocuments.org/Docs/VA-First-Home-Care-2012.09.12-CAP1.pdf (finding three employees providing mental health services who lacked required experience to do so at UHS's First Home Care); CMS, *SDPC* 12–16 (inspection Nov. 24, 2010), http://researchdocuments.org/Docs/GA-South-Crescent-Anchor-2010.11.24.pdf (finding Director of Social Work at UHS's Anchor Hospital in Georgia did not have minimum qualifications for the job).

supervision. Recent inspection reports indicate that inadequately trained and supervised staff provide care at many UHS facilities.

In Ohio, for example, inspectors twice found inadequately trained staff providing care at UHS's Foundations for Living. *See* Ltr. from Janel M. Pequignot, Ohio Dep't of Addiction Servs., to Connie Rebane, CEO, Founds. for Living 1, 3 (May 12, 2014), http://researchdocuments.org/Docs/OH-SOD-foundations-for-living-Noncompliance-letter-2014.05.12.pdf/. Even after warning Foundations that untrained staff could not physically restrain patients, inspectors returned to find that an untrained staff member had pushed a patient against a wall and bent his arm behind his back. *See id.*

And in Virginia, UHS paid $6.85 million in 2012 to settle claims that Marion Youth Center, which billed Medicaid for residential treatment services for children, in fact operated as little more than a detention center with no physician supervision or physician-supervised active treatment actually provided. *See* Settlement Agreement, *United States ex rel. Johnson v. UHS*, No. 1:07-CV-000054 (W.D. Va. March 28, 2012); Am. Compl. (Nov. 24, 2010) (same case). The United States and Virginia intervened in the Marion Youth Center case after it was filed by former employees.

Many additional examples of UHS training and supervision violations are cited in the margin.[3]

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[3] Wa. State Dep't of Health, *SDPC* 2–6 (inspection Nov. 6, 2014), http://researchdocuments.org/Docs/WA-Schick-Shadel-SOD-2014.11.07-DOH.pdf (finding that not all staff had CPR and first aid training cards and some staff had not been

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oriented, including with respect to patient rights and fire and disaster plans); Office of Licensing, Va. DBHDS, *Corrective Action Plan* 19–20 (inspection Mar. 31, 2014), http://researchdocuments.org/Docs/VA-Harbor-Point-2014.03.31-CAP.pdf (finding inadequate training in five staff members' records at Harbor Point Behavioral Health); CMS, *SDPC* 3 (inspection Sept. 10, 2014), http://researchdocuments.org/Docs/TX-SOD-Austin-Oaks-Hospital-2014.09.10.pdf ("supervision of ... care" violation at Austin Oaks hospital because vital signs were not monitored as directed by physician in eight of ten patient cases reviewed); Office of Licensing, Va. DBHDS, *Corrective Action Plan* 1 (inspection May 19, 2014), http://researchdocuments.org/Docs/VA-Virginia-Beach-Psych-Ctr-2014.05.19-CAP.pdf (finding inadequate training at Virginia Beach Psychiatric Center); Ga. Healthcare Facility Regulation Div., *SDPC* 1 (inspection Dec. 5, 2014), http://researchdocuments.org/Docs/GA-lakebridge-2013.12.05.pdf (finding, at Lake Bridge Behavioral Health System, facility failed to ensure required crisis prevention intervention training for seven of nine sampled files, including three of three nurse practitioners); Office of Licensing, Va. DBHDS, *Corrective Action Plan* 1 (inspection Sept. 9, 2013), http://researchdocuments.org/Docs/VA-First-Home-Care-2013.09.09-CAP.pdf (finding no evidence of adult CPR training for two employees); CMS, *SDPC* 2 (inspection Aug. 15, 2013), http://researchdocuments.org/Docs/CT-SOD-Stonington-Institute-2013.08.15.pdf (finding no effective government body specific to the facility); AHCA, *SDPC* 4 (inspection Aug. 7, 2013), http://researchdocuments.org/Docs/FL.Vines-RTC-2013.08.07.pdf (finding the Vines facility failed to provide adequate training to staff working with children); CMS, *SDPC* 1–4 (inspection May 31, 2013), http://researchdocuments.org/Docs/TX-Glen-Oaks-Hospital-2013.05.311.pdf (finding, at Glen Oaks Hospital in Texas, that the governing board failed to monitor the effectiveness, quality, and safety of services, and the facility failed to ensure and document restraint training for twelve of fourteen staff members, leaving instructor to teach from "personal experience" without training materials); Office of Licensing, Va. DBHDS, *Corrective Action Plan* 4–5 (inspection Apr. 22, 2013),
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http://researchdocuments.org/Docs/VA-Harbor-Point-2013.04.22-CAP.pdf (at Harbor Point, finding no evidence of required training for two employees, as well as supervision notes that appeared to be written by staff, putting "in doubt if appropriate supervision is being delivered," and "no evidence of on-going supervision" for another therapist); Office of Licensing, Va. DBHDS, *Corrective Action Plan* 2 (inspection Apr. 2, 2013), http://researchdocuments.org/Docs/VA-Poplar-Springs-2013.04.02-CAP.pdf (finding employee inadequately supervised at Poplar Springs facility); CMS, *SDPC* 2, 17 (inspection Nov. 29, 2012), http://researchdocuments.org/Docs/TX-Millwood-Hospital-2012.11.29-highlighting-added.pdf (finding, at Millwood Hospital in Texas, that governing body "was not effective in its oversight of the hospital," the "Medical Staff failed to adequately supervise and ensure a safe environment," and infection control was inadequate, in part because new control officer "was supposed to" be trained, but apparently had not been trained yet, and had no experience except what she was learning on the job); CMS, *SDPC* 2, 17 (inspection Aug. 2, 2012), http://researchdocuments.org/Docs/NC-Holly-Hill-2012.08.02.pdf (finding that Holly Hill Hospital failed to ensure corrective actions after incident "were implemented and monitored for effectiveness," and facility had "no formal re-training of the 15-minute observation rounds" and monitoring of the rounds was "inconsistent") Tex. Dep't of State Health Servs., *SDPC* 2–8, 23–29 (inspection March 8, 2012), http://researchdocuments.org/Docs/TX-Hickory_Trail_Hospital-2012.03.08_1.pdf (finding that Dietary Director did not manage and/or supervise department in responsible manner and facility did not provide adequate training); AHCA, *SDPC* 36–39 (inspection Feb. 21, 2012), http://researchdocuments.org/Docs/FL.Vines-RTC-2012.02.21.pdf (at The Vines, finding that fifteen of fifteen staff records failed to show training in time-out procedure, and six staff interviewed all had different understandings of procedure; facility also failed to ensure training in restraint and seclusion); CMS, *SDPC* 12–16 (inspection Nov. 24, 2010), http://researchdocuments.org/Docs/GA-South-Crescent-Anchor-2010.11.24.pdf (finding Medical Director at Georgia's Anchor Hospital did not adequately monitor care provided to patients).

Unsafe staffing levels. UHS facilities have also been cited repeatedly for failing to have enough staff on hand to ensure patient safety. These violations, too, put patients at risk.

UHS's University Behavioral Center ("UBC") in Florida provides one example. When state agency officials visited the facility in 2012, they found that UBC had failed not only to report suspected child abuse and to provide front-line staff with effective communication equipment but also to employ enough staff to care for its young patients. AHCA, *SDPC* 1, 8, 12 (inspection May 29, 2012), http://researchdocuments.org/Docs/FL.University-Behavioral-Center-2012.05.29.pdf. One nurse described a "near riot" among boys in the facility during a period of under-staffing. *Id.* at 9. The facility's CEO reported receiving calls about staff needing help but said he was frustrated a nurse called him rather than a weekend supervisor. *Id.*

Given UHS's understaffing, it is not surprising that the company's facilities are often cited for leaving patients unattended and without care and services they need. In Texas, for example, UHS's Texoma Medical Center left a newly discharged patient alone at a bus stop with instructions to take a 200-mile bus trip home. According to a subsequent inspection report, no discharge plan was prepared for the patient, who had been admitted not long before for planning to jump off a bridge and who was on suicide precautions on the day of discharge. The patient was found dead under a bridge within twenty-four hours after being abandoned by Texoma at the bus stop. *See* CMS, *SDPC* 1–2 (inspection Jan. 29, 2015), http://researchdocuments.org/Docs/TX-SOD-Texoma-Medical-Center-2015.01.29-immediate-jeopardy-violations.pdf; *see also* CMS,

SDPC 1–14 (inspection Oct. 9, 2014), http://researchdocuments.org/Docs/TX-SOD-Texoma-Medical-Center-2014.10.09-immediate-jeopardy-violations.pdf (same facility cited in 2014 for failing to put safety measures in place to protect patients who were able to attempt suicide).

Other examples of understaffing and inadequately attended patients are cited in the margin.[4]

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[4] AHCA, *SDPC* 1–11 (inspection Sept. 29, 2014), http://researchdocuments.org/Docs/FL-SOD-Palm-Shores-Behavioral-Health-Center-2014.09.29-5712654.pdf (finding that when staff member at Florida facility left patient, patient was able to self-harm); AHCA, *SDPC* 1–2 (inspection May 22, 2014), http://researchdocuments.org/Docs/FL.Sandy-Pines-2014.05.22.pdf (finding that facility failed to meet minimum staffing ratio requirement); CMS, *SDPC* 2–3 (inspection May 12, 2014), http://researchdocuments.org/Docs/KY-SOD-Cumberland-Hall-2014.05.12.pdf (finding that patient was able to attempt suicide while one mental health technician was left to care for eighteen patients and was unable to complete a fifteen-minute check "[d]ue to activity on the unit"); CMS, *SDPC* 53 (inspection Apr. 11, 2014), http://researchdocuments.org/Docs/LA-SOD-Brentwood-Hospital-2014.04.11-CMS.pdf (at Brentwood Hospital in Louisiana, finding "the hospital failed to ensure the nursing service had adequate numbers of licensed registered nurses, licensed practical nurses, and mental health technicians to provide nursing care to all patients as needed"); CMS, *SDPC* 51 (inspection Feb. 19, 2014), http://researchdocuments.org/Docs/LA-SOD-Brentwood-Hospital-2014.02.19.pdf (at Brentwood, "[t]he number of staff present was not adequate to ensure the safety of all patients as evidenced by the alleged sexual misconduct that was allowed to occur"); CMS, *SDPC* 8–9 (inspection Aug. 15, 2013), http://researchdocuments.org/Docs/CT-SOD-Stonington-Institute-2013.08.15.pdf (finding that Stonington Institute "failed to provide acute care nursing services to patients in the hospital"); CMS, *SDPC* 5 (inspection Dec. 5, 2012), http://researchdocuments.org/Docs/FL.Vines-Hospital-2012.12.

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05.pdf (after patient with psychosis was left unsupervised, an interviewed employee said "sometimes there are not enough staff to care for the residents and residents do not receive the care they should"); CMS, *SDPC* 6–7 (inspection Nov. 6, 2012), http://researchdocuments.org/Docs/FL.Emerald-Coast-Behavioral-Hospital-2012.11.06.pdf (finding that two patients at Florida facility were left unobserved longer than they should have been, allowing one to perform oral sex on the other); Tex. Dep't of State Health Servs., *SDPC* 25 (inspection March 8, 2012), http://researchdocuments.org/Docs/TX-Hickory_Trail_Hospital-2012.03.08_1.pdf (finding that Hickory Trail Hospital "failed to provide adequate nursing staff to ensure the safety of the facility's patients and staff"); Ga. Healthcare Facility Regulation Div., *SDPC* 4 (inspection Feb. 24, 2012), http://researchdocuments.org/Docs/GA-lighthouse-2012.02.24.pdf (finding that contrary to rule, a registered nurse was not present for more than 25% of night shifts in a three-month period); CMS, *SPDC* 8 (inspection Dec. 21, 2011), http://researchdocuments.org/Docs/TX-Timberlawn-Mental-Health-System-2011.12.21.pdf (finding that during violent incident, staff barricaded themselves in nursing station, leaving patients unprotected); Ga. Healthcare Facility Regulation Div., *SDPC* 1–9 (inspection Sept. 29, 2011), http://researchdocuments.org/Docs/GA-Summit-ridge-2011.09.29.pdf (finding that patient not observed as often as s/he should have been was able to commit suicide); CMS, *SPDC* 1–10 (inspection Apr. 21, 2011) http://researchdocuments.org/Docs/GA-Peachford-Behavioral-SOD-2011.04.21-CMS.pdf (citing facility for failing to have effective system for monitoring patients after patient found dead; records showed monitoring every fifteen minutes but video proved those records false); CMS, *SDPC* 1–10 (inspection Mar. 18, 2011), http://researchdocuments.org/Docs/MO-Two-Rivers-Behavioral-Health-2011.03.18-CMS.pdf (suicidal patient in UHS facility in Missouri was not observed as often as s/he should have been and was found unconscious).

2. Violations UHS Would Likely Dismiss as "Technical" Lead to Serious Harm.

Staffing violations that UHS would likely dismiss as "technical" often have devastating consequences for patient care, as at NDA and in many of the other facilities already mentioned.

UHS's Fairmount Behavioral Health facility provides a notable example. In 2012 inspectors cited Fairmount, located near UHS headquarters, for employing staff without timely completed background checks. *See* Pa. OMH, *Licensing Inspection Summary* 2 (inspection Jan. 24-27, 2012), http://researchdocuments.org/Docs/PA-Fairmount-Behavioral-Health-2012.01.24-DHS.pdf. Fairmount promised to "ensure" that all staff had timely completed clearances in the future, *id.*, but inspectors returned to find a staff member working without a required clearance in December 2013. *See* Pa. OMH, *Licensing Inspection Summary* 1 (inspection Dec. 11-13, 2013), http://researchdocuments.org/Docs/PA-Fairmount-Behavioral-Health-2013.12.11-DHS.pdf.[5]

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[5] *Cf.* Pa. OMH, *Licensing Inspection Summary* 5 (inspection Dec. 1-4, 2014), http://researchdocuments.org/Docs/PA-Friends-Hospital-IP-2014.12.01-DHS.pdf (at Friends Hospital, finding that nine of nine new staff members did not have FBI clearances on file and one staff member did not have clearance from Child Protective Services on file); Pa. OMH, *Licensing Inspection Summary* 1, 4–5 (inspection Apr. 30, 2014 & May 1, 2014), http://researchdocuments.org/Docs/PA-Roxbury-Treatment-Center-2014.04.30-DHS.pdf (at Roxbury Treatment Center in Pennsylvania, finding four personnel records were missing child abuse clearances and one was missing FBI clearance, as well as other records showing late or outdated clearances); AHCA, *SDPC* (inspection May 1, 2012), http://researchdocuments.org/Docs/FL.Gulfcoast-Treatment-

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In the period between the 2012 and 2013 inspections, a former Fairmount patient filed suit alleging that she was raped at the facility by an employee Fairmount had hired notwithstanding his extensive criminal record. *See* Second Am. Compl. ¶¶10–51, *Weismantle v. Walker*, No. 120402710 (Phila. Cnty. Ct. of Common Pleas Aug. 10, 2012), *available at* http://researchdocuments.org/Docs/PA-Philadelphia-2012-Weismantle-Complaint.pdf; Civ. Docket Rep. (same case), *available at* http://researchdocuments.org/Docs/Weismantle%20Civil%20Docket%20Report%202014.pdf. The former patient, a survivor of childhood sexual abuse, alleged that Fairmount's employee began harassing her almost immediately upon her admission, passing her notes that asked her to "have some good sex with [him]" and "[d]o you squirt when you come," before raping her two days after she arrived. Second Am. Comp. ¶¶10–26. The former patient alleged that her attacker pleaded guilty to her rape after a police investigation. *Id.* UHS settled the patient's lawsuit in 2014. *See* Civ. Docket Rep., entry dated Sep. 8, 2014.

Many other violations that UHS would likely describe as "technical" have been linked to terrible consequences as well. For example, an inspection at

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Center-2012.05.01.pdf (at Gulf Coast Treatment Center in Florida, finding that "the background screening process was not completed for 9 of 13 sampled staff members"; facility's second background-screen violation in fourteen months); AHCA, *SDPC* 3 (inspection Mar. 1, 2011), http://researchdocuments.org/Docs/FL.Gulfcoast-Treatment-Center-2011.03.01.pdf (also at Gulf Coast, finding that "none of the 10 sampled personnel records revealed Level 2 background screens performed in accordance with the AHCA's requirements").

UHS's Old Vineyard facility (where a nurse with a revoked license served as Director of Acute Services, *see* discussion *supra*) found that employees had briefly lost "line of sight" view of two patients. As a result of that violation, patients aged twelve and thirteen were left unobserved long enough to engage in oral sex. CMS, *SDPC* 5–18 (inspection Apr. 16, 2009), http://researchdocuments.org/Docs/NC-Old-Vineyard-2009.04.16-2.pdf.

While not all violations like these and the other examples cited above will give rise to claims for fraud under the False Claims Act, these examples do show how at least some of the regulations UHS dismisses as "technical" play an important role in patient safety, which could make their systemic violation significant to payers.

3. UHS's and Administrative Agencies' Inadequate Responses and the Cycle of Repeat Violations

UHS's violations are not only common and serious but often repeated as well. Federal and state agencies require "plan of correction" after "plan of correction" to no avail, and UHS facilities continue to commit the same violations again and again.

As UHS's CFO indicated when he spoke about "fairly minimal" scrutiny and operating "under [the] radar," Filton, *2013 Presentation*, *supra*, at 5, the federal and state regulators charged with overseeing Medicare and Medicaid providers are stretched thin and cannot adequately perform their oversight functions. The relevant administrative agencies are in many cases under-funded, *see, e.g.*, Kay Lazar, *Citing Backlog, State Health Agency Pleads for Funds*, Boston Globe (May 14, 2013), and even when they can investigate and discover violations, are

often without authority to levy fines or impose other meaningful sanctions short of termination from government programs. *See* Carlson, *supra*; *see also infra* Part II.A. Oversight agencies are thus left to require meaningless plans of correction that facilities then violate.

Any number of UHS facilities may be used to demonstrate the cycle of violation, correction plan, repeat violation. At Virginia's Kempsville Center, for example, inspectors returned two years after the facility submitted its plan to correct "systemic [staffing] deficiencies" to find staff without appropriate certifications again providing care. *See* Office of Licensing, Va. DBHDS, *Corrective Action Plan* 2 (inspection Oct. 9, 2013), http://researchdocuments.org/Docs/VA-Kempsville-2013.10.09-CAP.pdf. Also in Virginia, UHS's First Home Care was cited twice in one year—once after having submitted a corrective action plan—for employing staff without evidence that they met required qualifications. *See* Office of Licensing, Va. DBHDS, *Corrective Action Plan* 1 (inspection Sept. 9, 2013), http://researchdocuments.org/Docs/VA-First-Home-Care-2013.09.09-CAP.pdf; Office of Licensing, Va. DBHDS, *Corrective Action Plan* 2, 3 (inspection Sept. 12, 2012), http://researchdocuments.org/Docs/VA-First-Home-Care-2012.09.12-CAP1.pdf.

This same cycle of repeat violations can be seen at other UHS facilities as well.

A UHS facility in Florida was cited in 2011 and again in 2012 for missing background checks, first missing from ten of ten records reviewed and then from nine of thirteen records reviewed. *See* AHCA, *SDPC* 3 (inspection March 1, 2011), http://researchdocuments.org/Docs/FL.Gulfcoast-Treatment-Center-2011.03.01.pdf; AHCA, *SDPC* 3 (inspection May 1,

2012), http://researchdocuments.org/Docs/FL.Gulf coast-Treatment-Center-2012.05.01.pdf.

Another UHS facility in Texas was cited in 2012 and then again in 2013 for medication-related issues. *See* CMS, *SDPC* 3–8 (inspection Aug. 21, 2013), http://researchdocuments.org/Docs/TX-SOD-El-Paso-Behavioral-2013.09.17-POC.pdf; CMS, *SDPC* 11–13 (inspection Nov. 29, 2012), http://researchdocuments.org/Docs/TX-UBH-of-El-Paso-2012.11.29-2-highlighting-added.pdf.

And at UHS's Timberlawn facility in Dallas, inspectors found repeat violations last year of staffing and "care in a safe setting" requirements—violations the inspectors linked to patient injuries and death. One Timberlawn patient committed suicide by hanging herself after the hospital failed to remove ligature risks it had identified seven months before. CMS, *SDPC* 3–9 (inspection Feb. 25, 2015), http://researchdocuments.org/Docs/2015.02.25TX-Timberlawn-SOD.pdf. Another patient, ten years old, was assaulted and suffered a head injury during a period when staffing levels were inadequate. CMS, *SDPC* 3, 18 (inspection Apr. 22, 2015), http://researchdocuments.org/Docs/2015.04.22-TX-TImberlawn-SOD-a-tags.pdf. A third patient who had been sexually abused as a child reported being raped during another period of inadequate staff monitoring and supervision. CMS, *SDPC* 3–6 (inspection May 13, 2015), http://researchdocuments.org/Docs/2015.05.13-TX-Timberlawn-SOD.pdf.

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As all these examples show, UHS has a history of staffing and other regulatory violations that have been linked to serious patient harm, and neither administrative agency inspections nor the company's

"plans of correction" have protected the vulnerable patients in UHS's care.

II. IMPLIED-CERTIFICATION CLAIMS PLAY AN IMPORTANT ROLE IN PROTECTING PATIENTS AND DO NOT THREATEN "CATASTROPHIC" LIABILITY.

Misconduct like UHS's poses a serious threat to patient safety, and implied-certification claims deter that misconduct and encourage whistleblowers to report it. By eliminating implied-certification liability, UHS's narrow reading of the FCA would blunt the statute's effectiveness, weakening enforcement of rules and regulations that protect patients from harm and protect the government's investment in quality care. While UHS asserts that crippling the FCA is necessary to prevent "catastrophic" liability, Pet'r's Br. 55, all evidence, including UHS's own experience, contradicts that assertion.

A. The Important Role Played by Implied-Certification Liability

Implied-certification liability encompasses only a subset of healthcare provider frauds but plays an important role in protecting patients and in ensuring that the government receives the benefit of its bargain.[6] Implied-certification claims deter knowing and material rule violations that the current regulatory system is incapable of preventing on its own, and the prospect of recovery for such claims motivates whistleblowers to come forward.

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[6] In general, implied-certification liability refers to liability for the knowing submission of a claim that is false or fraudulent because it implies compliance with a material requirement that the claimant has in fact violated.

UHS's record shows how provider rule violations can lead to serious harm. Unsupervised staff prescribe dangerous medication. Resp'ts Br. 11–13. Inadequately trained employees fail to report abuse. *See supra* Part I.A. Staff members whose criminal records have not been checked rape patients in their care. *See supra* Part I.B.2.

Yet even when provider violations like these are knowing and material, the Medicare and Medicaid regulatory system struggles to identify and deter them. The system is hampered by the fact that provider inspections are often conducted by state agents, *see* 42 C.F.R. §488.10, whose limited jurisdiction prevents them from "addressing systemic issues," Conaboy, *National Reviews*, *supra*, and identifying "patterns ... across state lines." *Id.* (citing Ira Burnim, legal director of *amicus* Judge David L. Bazelon Center for Mental Health Law). The agencies charged with overseeing providers are also frequently under-funded and unable to investigate all the complaints they receive. *See* Lazar, *supra* (Massachusetts fell "significantly behind in investigating consumer complaints about medical facilities" after budget cuts); Twohey, *supra* (report finding Illinois health department investigated only 15% of hospital complaints—failing even to investigate "allegations of serious harm or death"—due to lack of funding.)

Equally problematic is oversight agencies' limited authority when inspectors *do* find violations. CMS may terminate providers' participation in its programs, *see, e.g.*, 42 C.F.R. §489.53, but rarely takes that drastic step, terminating only thirteen hospitals during a recent five-year period. Tina Reed, *Maryland Hospital Threatened With Loss of Medicare Funds*, Wash. Bus. J. (Oct. 6, 2015),

http://www.bizjournals.com/washington/blog/2015/10/maryland-hospital-threatened-with-loss-of-medicare.html. Short of termination, regulators' only option is often to require "plans of correction," which carry little weight. *See* 42 C.F.R. §488.28; *supra* Part I.B.3. In other words, because regulators are loath to terminate providers and in many cases lack "the power to levy fines" or impose other intermediate sanctions, they are "unable to respond to problems in a manner that ensures the problems won't happen again once the inspectors have left the premises." Carlson, *supra*; *see also* Survey & Certification—Enforcement, CMS (last modified Apr. 9, 2013), http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationEnforcement/.

For knowing and material rule violations, then, the prospect of implied-certification liability adds much-needed deterrence value. The FCA's financial penalties are for obvious reasons more likely to deter rule-related fraud than are plans of correction, and providers also know that implied-certification claims filed against them in multiple jurisdictions may alert government payers to systemic violations state inspectors miss. In UHS's case, for example, DOJ launched civil and criminal inquiries into the company's facilities after years of lawsuits alleging rule violations. *See* UHS, *Form 10-K* 29–31 (Feb. 25, 2016), https://www.sec.gov/Archives/edgar/data/352915/000156459016013375/uhs-10k_20151231.htm (citing ongoing DOJ investigations, including into many of the facilities discussed above).

In addition to deterring rule violations, implied-certification liability furthers the FCA's purposes by encouraging whistleblowers to report knowing and material misconduct.

As Congress noted when it amended the FCA, "[d]etecting fraud is usually very difficult without the cooperation of individuals who are either close observers or otherwise involved in the fraudulent activity." S. Rep. No. 345, at 4 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5269. Healthcare providers cannot be counted on to admit regulatory violations voluntarily, as demonstrated by their terrible record with respect to adverse incident reporting. *Few Adverse Events in Hosps. Were Reported to Adverse Event Reporting Sys.*, Office of Inspector Gen., U.S. Dep't of Health & Human Servs. ("OIG") (July 19, 2012), http://oig.hhs.gov/oei/reports/oei-06-09-00092.asp (hospitals reported only 1% of adverse and temporary harm incidents); *see also Hosp. Incident Reporting Systems Do Not Capture Most Patient Harm*, OIG (Jan. 5, 2012), http://oig.hhs.gov/oei/reports/oei-06-09-00091.asp. Thus, individual whistle-blowers are in many cases essential to uncovering fraud.

As important as they are, however, whistleblowers are unlikely to come forward without some meaningful incentive because they risk employer retaliation for doing so. Indeed, UHS and UHS facilities have themselves been sued for retaliation many times in recent years, often by employees who allege they were retaliated against because they objected to statutory or regulatory violations.[7] And in Massachusetts, where Yarushka

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[7] *See US Labor Department's OSHA orders reinstatement of whistleblower*, Occupational Safety & Health Admin. (June 7, 2012), https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=22500 (UHS's North Star Behavioral Health System fired employee who raised concerns about drinking-water safety at residential treatment center); First Am. Compl. ¶¶42–54, *Freeman v. Cardinal*

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Health Pharmacy Servs., No. 2:14-cv-01994 (E.D. Cal. Aug. 27, 2014), ECF No. 1 (Exh. A to Notice of Removal) (former Pharmacy Director at Sierra Vista Hospital alleged retaliation for reporting concerns about patient care, safety, and facility conditions); Compl, *Harrington v. UHS of Lakeside, LLC*, No. 2:14-cv-02276 (W.D. Tenn. Apr. 17, 2014), ECF No. 1 (alleging retaliation for sex harassment complaint about co-employee); Compl. ¶¶61–66, *Adogli v. BNC Heritage Oaks Hosp., Inc.*, No. 2:13-cv-00212 (E.D. Cal. Feb. 5, 2013), ECF No. 1 (alleging retaliation for participation in investigation of sex harassment and patient sex abuse); Compl. ¶¶22–29, *Weeks v. Keystone Charlotte, LLC & UHS, Inc.*, No. 3:11-CV-193 (W.D.N.C. Apr. 28, 2011), ECF No. 1 (alleging retaliation for reports of statutory and regulatory violations with respect to staff training, staff safety, and client care, supervision, and safety); Compl. ¶¶17–34, *Jones v. UHS, Inc.*, No. 1:10-cv-00046 (W.D. Va. July 29, 2010), ECF No. 1 (alleging retaliation for reporting Medicaid fraud); Second Am. Compl. ¶¶38–47, *Robberecht v. Permanente Med. Grp., Inc.*, No. 34-2012-00130238 (Sacramento Cnty., Cal., Super. Ct. Feb. 24, 2014) (alleging retaliation after employee learned of rape of patient at UHS facility); Compl. ¶¶41–53, *Maduagwu v. Del Amo Hosp. Ltd. P'shp*, No. BC535147 (L.A. Cnty., Cal., Super. Ct. Feb. 7, 2014) (alleging retaliation for objecting to statutory violations, including inadequate staffing and patient-safety problems); Compl. ¶¶24–32, *Sanchez v. BHC Sierra Hosp. Inc.*, No. 34-2013-00154381 (Sacramento Cnty., Cal., Super. Ct. Nov. 7, 2013) (alleging retaliation for objecting to threats and sexual assaults by staff, understaffing, and unsanitary and unsafe conditions); Compl. ¶¶11–13, *Barton v. Del Amo Hosp. Inc.*, No. BC463326 (L.A. Cnty., Cal., Super. Ct. June 10, 2011) (alleging retaliation for complaints about unsafe conditions, including understaffing); First Am. Compl. ¶42, *Olayinka v. UHS, Inc.*, No. RC088809 (L.A. Cnty.,, Cal., Super. Ct. Aug. 19, 2010) (alleging retaliation for objecting to violence at facility); Second Am. Compl. ¶¶39–46, *Gilrain v. NDA*, No. 2013 CA 00190 (Fla. Cir. Ct. Sept. 6, 2013) (alleging retaliation for reporting patient abuse and other unlawful conduct); Compl. ¶¶5–35, *Yost v. Horizons Mental Health Mgmt.*, No. 12PT225 (Wash. Cnty.,

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Rivera received treatment, a UHS employee and SEIU member was disciplined in 2014 for speaking publicly about dangerous conditions. Liz Kowalcyzk, *Union, Hospital Clash on Worker Who Spoke to Globe*, Boston Globe (July 20, 2014).

Given the risk of retaliation that whistleblowers face, financial incentives are essential to encouraging them to come forward. Congress recognized as much when it amended the FCA in 1986 to "provide [whistleblower] incentives." J. Randy Beck, *The False Claims Act and the English Eradication of Qui Tam Legislation*, 78 N.C. L. Rev. 539, 562–63 & nn. 107, 108 (2000). And recent empirical research confirms that "a strong monetary incentive to blow the whistle" does in fact "motivate people with information to come forward." Alexander Dyck *et al.*, *Who Blows the Whistle on Corporate Fraud?*, 65 J. of Fin. 2213, 2215 (2010); *see also* Pamela H. Bucy, *Private Justice*, 76 S. Cal. L. Rev. 1, 53 (2002) (the *qui tam* mechanism "attract[s] knowledgeable insiders").

Under the First Circuit's decision, the FCA's whistleblower incentive provisions will continue to operate effectively and as Congress intended with respect to knowing and material rule violations, motivating insiders to report them. Petitioners' reading of the statute, by contrast, would in many cases eliminate incentives for reporting even serious violations, likely leaving them undetected.

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Ohio, Ct. Common Pleas July 6, 2012) (alleging retaliation for reporting numerous care-related violations).

B. Implied-Certification Claims Do Not Threaten "Catastrophic" Liability.

Although implied-certification claims are important for the reasons just given, they do not threaten "catastrophic" liability. *Contra* Pet'r's Br. 55.

The FCA itself imposes meaningful limitations on liability that prevent any such result. The statute's materiality and scienter requirements are routinely applied, even at the pleading stage, to reject FCA claims. *See, e.g.*, *Thulin v. Shopko Stores Operating Co., LLC*, 771 F.3d 994, 1000 (7th Cir. 2014); *United States ex rel. Stephenson v. Archer Western Contractors, L.L.C.*, 548 Fed. Appx. 135, 138 (5th Cir. 2013); *United States ex rel. Ge v. Takeda Pharmaceutical Co. Ltd.*, 737 F. 3d 116, 124 (1st Cir. 2013). Courts also apply Rule 9(b)'s heightened pleading requirements, *see* Fed. R. Civ. P. 9(b), and the plausibility pleading standard to dismiss FCA complaints. *See, e.g.*, *Ge*, 737 F.3d at 124; *Thulin*, 771 F.3d at 1000; *United States ex rel. Guth v. Roedel Parsons Koch Blache Balhoff & Mccollister*, 2015 U.S. App. LEXIS 17353, at *9–10 (5th Cir. Sept. 29, 2015); *United States ex rel. Gage v. Davis S.R. Aviation, L.L.C.*, 623 Fed. Appx. 622, *7–14 (5th Cir. 2015). No matter the result in this case, these statutory and pleading requirements will still limit providers' liability.

Furthermore, data about fraud and FCA recoveries show that we are far from a catastrophic-liability regime. Healthcare fraud is estimated to cost the United States $80 billion per year. *See* FBI, *Rooting Out Health Care Fraud Is Central to the Well-Being of Both Our Citizens and the Overall Economy* (March 27, 2014), *archived at*

https://web.archive.org/web/20140327100638/http://www.fbi.gov/about-us/investigate/white_collar/health-care-fraud. But in 2015, FCA claims (which are by far the government's best source of fraud recovery[8]) generated only $1.9 billion in settlements and judgments involving healthcare companies. *See Justice Dep't Recovers Over $3.5 Billion from False Claims Act Cases in Fiscal Year 2015*, DOJ (Dec. 3, 2015), http://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015. If anything, statistics like these militate in favor of a stronger FCA, not a weaker one.

Similarly, UHS-specific data undermines the company's catastrophic-liability claims. UHS reported a $2.2 billion increase in net revenue between 2011 and 2015, *see* UHS, Form 10-K, *supra*, and the company continued to pursue rapid capacity growth in mental health, adding as many as 800 beds per year, *see* Filton, *2015 Presentation*, *supra*—all while numerous courts of appeals approved and applied the implied-certification theory of liability. UHS's CFO has even described the company's behavioral-health business as receiving "fairly minimal" scrutiny, Filton, *2013 Presentation*, *supra*, at 3, which sounds very different from the kind of boundless liability the company now claims to face for purposes of this litigation.

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[8] *See Fraud Statistics – Overview*, DOJ (Nov. 23, 2015), *available at* http://www.justice.gov/opa/file/796866/download.

CONCLUSION

For the foregoing reasons, the First Circuit's decision should be affirmed.

Respectfully submitted,

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